

CHILDREN'S MEDICAL REPORT

Name of Child \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Address of Parent or guardian \_\_\_\_\_  
(Street) (City) (State) (Zip)

MEDICAL HISTORY (May be completed by parent)

- 1. Previous hospitalization: Yes \_\_\_ No \_\_\_ If so, why? \_\_\_\_\_
2. Is child allergic to anything: Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_
3. Any previous disease or illness: Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_
4. Any Operations: Yes \_\_\_ No \_\_\_ If so, what type? \_\_\_\_\_
5. Any physical handicaps: Yes \_\_\_ No \_\_\_ If so, please describe: \_\_\_\_\_
6. Is child under the care of a doctor: Yes \_\_\_ No \_\_\_ If so, for what reason? \_\_\_\_\_
7. Any history of mental retardation: Yes \_\_\_ No \_\_\_
8. Any history of convulsions: Yes \_\_\_ No \_\_\_
9. Any history of diabetes in family: Yes \_\_\_ No \_\_\_
10. Any history of heart trouble? Yes \_\_\_ No \_\_\_

(Parent/Guardian's Signature)

PHYSICAL EXAMINATION: This examination must be completed and signed by a licensed physician or his or her authorized agent who is currently approved by the N.C. Board of Medical Examiners.

Weight \_\_\_\_\_ Height \_\_\_\_\_ Heart \_\_\_\_\_

Chest \_\_\_\_\_ Throat \_\_\_\_\_ Neck \_\_\_\_\_ Abdomen \_\_\_\_\_ GU \_\_\_\_\_ Ext. \_\_\_\_\_

Neurological System \_\_\_\_\_

Teeth \_\_\_\_\_ Skin \_\_\_\_\_ Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_

Results of Tuberculin Test, if given: \_\_\_\_\_  
(Type) (Results)

Should activities be limited? \_\_\_\_\_

Recommendations: \_\_\_\_\_

(Signature of physician or authorized agent who is currently approved by the NC Board of Medical Examiners)

Date of examination

ECIM PEDIATRICS
2604 Martin Luther King Jr. , Blvd. New Bern, NC 28562
252-636-1919

C. Immunization History:

The day care operator or health official must enter the date immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all day care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP/DTaP/DT (Circle Which)					
*IPV/OPV (Circle Which)					
**HIB					
*MMR (Combined doses)					
MEASLES (Single doses)					
MUMPS (Single doses)					
RUBELLA (Single doses)					
***HEP B					
VARICELLA					

\* Required by State Law.  
 \*\* Required by State Law for  
 children born on or  
 after 10/01/91.  
 \*\*\*Required by State law  
 for children born on or  
 after 7/01/94.